CHAPTER 4
THE PLANNED SYSTEM OF CARE FOR CHILDREN AND YOUTH

The system of care for children and youth must reflect the fact that children and youth are different from adults in terms of their needs and the interventions necessary to serve them. Children and youth, unlike adults, must negotiate a magnitude of developmental tasks resulting from their growth in physical, cognitive, cultural, social, and emotional domains. Another difference from adults is that children and youth are physically, emotionally, economically, and legally dependent upon adult family members and caretakers. Therefore, the system of care for children and youth must promote their growth and natural development through prevention services and treatment interventions. To be successful, the system of care for children and youth must recognize the importance of family members and caretakers and the impact of culture on access and utilizing mental health services. Every effort must be made to include the culture of the family members and caretakers in culturally aware service planning, treatment decisions, and long-term support of children and youth.[1]

WHAT ARE THE VISION, MISSION, AND VALUES FOR A SYSTEM OF CARE FOR CHILDREN AND YOUTH?

The mental health constituency envisions a society in which families[2] can raise happy, healthy, competent, and resilient children. The public mental health system promotes this vision through participation in a community-based system of care, which fosters optimal child development. The purpose of creating a public mental health system that collaborates with the larger Children's System of Care is to accomplish the following goals for children and their families:

- Children are healthy
- They are safe
- They live at home
- They are productive at school or at work
- They have supportive relationships with others
- They have meaningful connections to their communities
- They abide by the law

The following values guide development and implementation of children's mental health services components within the larger system of care:

1. **Cultural proficiency**—Cultural proficiency of the system of care is essential to assuring access, voice, choice, and ownership to children and their families.
2. **Basic rights**—Children and youth with serious emotional disturbances have all rights, privileges, opportunities, and responsibilities accorded to other minors. Advocacy to protect and insure those rights and access to resources should be an integral part of the system of care.
3. **Early identification and intervention**—Children with mental health needs should be identified early and provided with appropriate services. Serving infants and very young children at high risk of developing mental heath problems enhances the likelihood of positive outcomes in mother-infant bonding, family integration, and stability.
4. **Access, voice, choice, and ownership**—Children and their families should actively participate in and agree to all aspects of services they receive, including assessment, plan development, and treatment. They should participate in all aspects of policy development, program planning, services delivery, and oversight.
5. **One family, one plan**—All agencies involved with a child and family should join with the child and family to develop a single, coordinated service plan. Services should be delivered seamlessly with funding

[1] The California Mental Health Planning Council (CMHPC) gratefully acknowledges the contributions of Charles Anders, dave neilsen, and Todd Sosna, PhD, to this chapter.

[2] The term "family" is used in its broadest sense to include any adults who have legal responsibility for the care of a child, such as biological parents, foster parents, relatives, and other guardians.

mechanisms invisible to the child and family.

6. **The more complex the need, the more unique the response**—Service plans should be individualized to meet the goals identified by the child and family while building on their strengths and resources. Families with the most complex needs should have services uniquely tailored to meet those needs.
7. **Success is the only way out**—Services should be unconditional with a no-eject, no-reject policy.
8. **Community based**—All services, including residential, should be provided in the home community unless no appropriate local resources are available. Although some children and youth may require more restrictive care at various times, promptly returning them to a more natural environment should be one of the main goals of service planning.
9. **School based**—Schools are vitally important to all children and youth. School-based mental health services not only respond to the needs of identified children and youth but also can address the needs of children and youth identified as potentially high risk.
10. **Recreation**—Playing sports, socializing with peers, and engaging in other recreational activities are important to children's development. Providing children and youth with after-school and summer programs is an integral component of a system of care.
11. **Natural supports**—In working with families, the mental health system should assist them to identify and develop natural supports in the community.
12. **Support for families**—Families with children and youth with serious emotional disturbances need supportive services, such as education about serious emotional disturbances and mental illnesses, respite care, after-school care, crisis services, support for siblings, training in accessing public benefits, and peer support groups for parents and foster parents with similar problems.
13. **Support during transitions**—Transitions are challenging. For most children and youth, changes in routines are difficult, and they and their families need planned support during transitions between programs. Youth in transition to adulthood may need special services to assist them in making that transition successfully.
14. **System accountability**—Policies, programs, and services should be ethical, legal, effective, and cost effective. Accountability is provided by specifying measurable goals and through regular evaluation of policy, program, and service outcomes.
15. **Funding**—State and local funding policies and mechanisms should support the concept of community-based systems of care. Fiscal incentives to mental health programs and other agencies should encourage the least restrictive, most appropriate services. Flexible funds should be available to allow special items or services to be purchased.

The Concept of an Inclusive System of Care

A clearly identified target population has been a fundamental element of the system of care planning model since its inception in the mid-1980s. By using a focused definition of the target population, local mental health departments and other child-serving agencies were able to maximize their limited service capacity for a fairly narrow population of high-risk children and youth with serious emotional disturbances. Especially in the earlier years of system of care development, this service, which focused on a small but well-defined target population, proved effective in diverting children and youth from restrictive, high-cost group homes and returning them to their own families. This initial success demonstrated the increased relevance of mental health services to other child-serving agencies and established local mental health departments as a key partner in building effective collaborations among public agencies. In the initial stages of Children's System of Care development, this narrowly defined target population was placed in statute as the group with the highest priority for receiving services and was consistent with a narrowly defined concept of system of care.

Now, fifteen years later, nearly all county mental health programs in the State are funded for Children's System of Care development.

The relevance of mental health services to public partner agencies and the access those agencies have to mental health services for their children and families are once again being examined. The historical Children's System of Care "target population" has become less critical as a screening tool due to stabilized funding for community mental health programs. At the same time, new evidence suggests that significant improvement in child and family well-being can be achieved through providing appropriate mental health services. For example, major initiatives launched by the Department of Social Services and probation agencies are highly dependent upon the successful integration of specialty mental health services into service plans for at-risk children and youth. In addition, new initiatives from entities outside traditional system of care partners, such as Healthy Families, have received much public attention in the field of services to children.

These initiatives underscore the need for expanding the involvement of the public mental health system to a broader range of children, youth, and families. Such expansion also calls for a more inclusive definition of the system of care target population. The population to be served by the Children's System of Care should include all children who receive services from the primary child-serving public agencies, including those children who are potentially eligible for services, such as children who are at risk of out-of-home placement. Priority should be placed on early identification of children and youth at risk so that their symptoms do not become so severe that they require more intensive service. Mental health services should be delivered to this expanded system of care population so that these children might be spared a whole array of negative life outcomes, including out-of-home placement, juvenile justice involvement, and school failure.

Another reason to adopt the inclusive system of care concept is that the narrower system of care concept does not promote the correct fiscal incentives. With the narrower system of care, pressures exist for cost-shifting and transferring responsibility for the care and treatment of children among county agencies serving children. This cost shifting occurs because some of the partner agencies in the Children's System of Care are facing significant challenges. In education, class size reductions have resulted in a shortage of space for support staff, special education classes, and collaborating agencies, such as mental health, probation, and social services staff. Schools are dealing with increasing pressure to improve standardized achievement test results. This pressure is contributing to a move toward "zero tolerance," ejection of students who misbehave sometimes for relatively minor infractions. Suspending or expelling students from school can create behavioral problems that put pressure on their families and other child-serving agencies. In the child welfare system, placements have risen with particular pressure on the most intensive level of placement: RCL 12-14. In the mental health system, Metropolitan State Hospital is now the only state hospital available for children. Community treatment facilities, which would provide secure placement options, are available only to a limited degree. Recent legislation requires that the Interstate Compact Placement Committee rigorously screen out-of-state placements by child welfare and juvenile probation. Mental health placements do not have this requirement, which puts additional pressure on children to be placed through the Chapter 26.5 process so that very disturbed children who are in need of contained settings can receive an appropriate placement.

A better strategy would be one in which a county as an administrative unit has ultimate responsibility for the clinical and fiscal outcome for children and their families. The concept of an inclusive system of care is based on shifting the point of responsibility from the individual child-serving agencies to the county level. The high degree of interdependency among agencies means that one agency cannot excel in achieving good outcomes unless it works collaboratively with other agencies to achieve goals that have been established in common. The locus of responsibility for managing care should be at the level of the county governing body. At that level, the goals are protection of the county general fund and improvement of community well-being. One of the strategies for achieving those goals is to improve outcomes for children and youth who are potentially high-risk and high-cost. Implementation of this approach has implications for increased partnership, particularly with education, but also with

informal supports for families, such as the faith community and grassroots organizations.

WHY DOES A SYSTEM OF CARE WORK AND HOW IS IT STRUCTURED?

California is a national leader in promoting mental health systems of care for children and their families. The system of care and its required components are specified in state legislation. Required components in a system of care include family partnership, cultural proficiency, a full continuum of community-based services and supports, cross-agency collaboration, and evaluation of outcomes. However, the manner in which Children's System of Care components is expected to address these requirements is not detailed. The success of systems of care is, in part, responsible for collaborative programs being promoted by other service systems, including child welfare, juvenile justice, schools, and public health. However, many communities have service delivery systems made up of collaborative, but fragmented, programs. This fragmentation typically results from rapid expansion and hurried strategic planning. In addition, the local collaboration sometimes loses its focus on how to integrate all these efforts.

Goodness of Fit Theory of Change

Mental health is critical to a person's success as an individual, a family member, and as part of the community. Mental health is necessary for critical functions, such as motivation, planning, learning from the consequences of one's actions, impulse control, social interactions, empathy, and altruism. Impairment in these important functions can result in severe impairment in many areas, such as employment, raising children, getting along with others, meeting basic needs for food, shelter, health, and clothing, learning in school, and abiding by the law. Public agencies have been established with dedicated resources and specialized staffing and expertise to address problems, such as homelessness, unemployment, child abuse and neglect, crime, access to health care, and failure to benefit from schooling. Specific services and programs available from county mental health departments are described in the appendix to this chapter.

Each of these agencies is successful with many of the children and families that they serve; however, a small percentage of children and families are not successful despite receiving services from the responsible agencies. This small percentage of children and families tend to account for a disproportionately large percentage of need. Failure to benefit from typical services offered by the responsible agencies can be explained by the profound effects of mental disorders and substance abuse. As a consequence, success with these children and families will require the combined efforts of several agencies working to address areas of impairment and underlying mental health disorders.

The Children's System of Care needs a "theory of change" that explains why these components individually or in combination will result in better outcomes for children and families. The relevance and significance of theories of change for collaborative programs is profound. Collaborative programs are formed to achieve better child and family outcomes at the same or lower cost. Collaboratives are successful when members of the collaborative work in concert to build on each other's strengths, resulting in a product that is greater than the sum of its parts. Collaboratives benefit from the enhanced decision making that results from teamwork. In order for a collaborative to make decisions successfully, the team benefits from having a shared theory of change that is a composite of the approaches that characterize the agencies that form the collaborative. The "goodness of fit" theory of change offers tremendous promise for children's mental health systems of care as well as collaboratives being promoted in other service systems.

The benefits of the children's mental health systems of care as well as similar reforms promoted by child welfare and juvenile justice systems (e.g. wraparound, family unity, and family group conferencing) can be explained by a "goodness of fit" theory. This theory is premised on individualized care that builds on child and family strengths. The term, goodness of fit, means that the services provided to a child and family fit well with their strengths and needs. This theory provides plausible explanations for why the systems of care are needed and why they work.

The best outcomes in terms of both child and family functioning and cost are directly related

to the goodness of fit between child and family strengths and needs and the level of care provided. In the absence of an appropriate and precise fit, a child will be over- or underserved. Imprecision or mismatch in service level is directly related to unachieved outcomes and waste.

The adverse consequences of over-serving include:

- Limited positive outcomes
- Exposing a child and family to overly intrusive and restrictive interventions
- Unnecessary costs
- Fostering dependence on service providers
- Undermining child and family autonomy

The adverse consequences of under-serving include:

- Absence of positive outcomes
- Wasted expenditure of time and resources
- Unrealized hopes
- Loss of confidence in effectiveness of future interventions

Achieving a good fit requires building on child and family strengths to promote meeting their needs and achieving their goals. The importance of each component of a system of care described below can be understood in terms of its relation to promoting strengths-based, individualized care or "goodness of fit."

- **Family partnership** is necessary to identify child and family strengths and the goals of the child and family and to promote hope, child and family participation, and sharing of information.
- **Collaboration** is necessary to promote coordination of care across agencies, access to cross-agency services, and expansion of the local continuum of care and to improve planning through cross-agency and interdisciplinary expertise.
- **A full continuum of community-based services and supports** is necessary to promote access, to build on family and community strengths and resources, and to improve generalization of gains.
- **Evaluation of outcomes** is necessary to promote informed decision-making about services and systems change, and to improve quality of care, advocacy, and sustainability of effective service delivery reforms.

Structure of the Children's System of Care

To implement individualized, strengths-based services, a system of care must have certain physical elements to perform its various functions. These functions include identifying children who need an individualized service plan, designing the interagency service delivery system, developing programs and services, providing individualized service planning and implementation, ensuring family member participation, and conducting system evaluation. These functions should be performed by the individual agencies participating in the Children's System of Care, the interagency policy council, the interagency case management committee, service providers, an evaluator, and youth and family member involvement. This section describes these physical elements and the functions they perform in the Children's System of Care.

The **interagency policy council** designs and guides the Children's System of Care. The director of each child-serving agency in the county and senior management staff should participate in the interagency policy council. The interagency policy council performs the same functions for the Children's System of Care that an agency director performs for his or her own agency. These functions include developing a vision for the system and imparting that vision to staff; designing new interagency programs and services; designing the manner in which children enter the system, receive services, and exit the system; and monitoring the system to improve performance.

The system must include a process for identifying and referring children and their families who need an individualized service plan to experience positive outcomes. The system of care should develop a screening tool that identifies those children who are most likely to experience poor outcomes if served by the traditional service delivery system. The

traditional delivery system refers to a single child-serving agency providing just its services to a child and family as opposed to multi-agency interventions for children and families with more complex needs. The children and families that come into contact with a public agency should be screened by that public agency and referred to either a single child-serving agency for traditional intervention or to the interagency case management committee to develop an individualized service plan.

The **interagency case management committee** includes staff from the major child serving agencies. The staff should have the authority to commit resources to a service plan. The interagency case management committee is responsible for developing and implementing the individualized service plan for the children and families who are referred to them. Families are referred to the interagency case management committee because they need services from more than one child-serving agency in the county.

Separate from the service planning and implementation process is an evaluation component. The Children's System of Care should employ an **evaluator** to monitor staff fidelity to the service planning and implementation process and to evaluate outcomes for children and their families. This information must be fed back to management so that it can improve service planning and delivery. The information must also be fed back to the interagency policy council so that it can improve adherence to system processes or adjust system processes to improve outcomes.

The Children's System of Care must also have **family members and youth** involved at the policy level, in service planning and implementation, and the evaluation process. The service delivery system is designed to meet the needs of children, youth, and their families. Family members have first-hand knowledge about what is and is not effective at the system and service delivery level. This input must be valued and incorporated into designing and operating the Children's System of Care. This type of information will help the evaluator better identify what needs to be evaluated as well as how to best implement the evaluation process to include other family members.

So far, this discussion has focused on formal elements of the system of care, such as service providers and county infrastructure for implementing the system of care approach. Of equal importance are the informal elements for supporting children and families in the community. These informal elements are sometimes referred to as natural supports and include extended family, churches, neighbors, schools, mentors, and co-workers.

Figure 1 on the following page clarifies the relationship of the formal and informal partners in a system of care. At the center of the system of care is the child, surrounded by the immediate family. This circle forms the heart of a family's support system. Extended family, friends, and neighbors are in the next two rings of the circle. These individuals are informal sources of support that a family can rely on when it needs assistance. Other natural resources, such as schools and faith communities, surround this group. The next circle represents the formal resources provided by public agencies. Finally, in the outermost circle are state and federal agencies that provide the statutory and fiscal framework for the formal support agencies. When children and their families need assistance, they use available resources in ever widening circles. A system of care will assist families to strengthen their natural resources so they can rely on informal supports, eventually reducing the need for public agency involvement.

WHAT INNOVATIVE PROGRAMS HAVE BEEN DEVELOPED FOR CHILDREN?

Federal, state, and county governments have been developing innovative programs that are consistent with the vision, mission, and goals of the Children's System of Care. This section highlights those initiatives.

Wraparound Services

Chapter 795, Statutes of 1997, (SB 163), allows counties in California to participate in a five-year pilot project. The purpose of the pilot project is to provide eligible children with family-based service alternatives to group home care. The wraparound pilot project focuses on a family-centered, strengths-based, needs-driven planning process for creating individualized services and supports for children, youth, and their families. These services facilitate access to normalized and

inclusive community options, activities, and opportunities. The legislation permits flexible use of state foster care funds and Adoption Assistance Program funds to pay for individualized, intensive wraparound services necessary to keep these children in family settings or to return them to families. The legislation targets children who are currently residing in or are at risk of being placed in the highest levels of group home care.

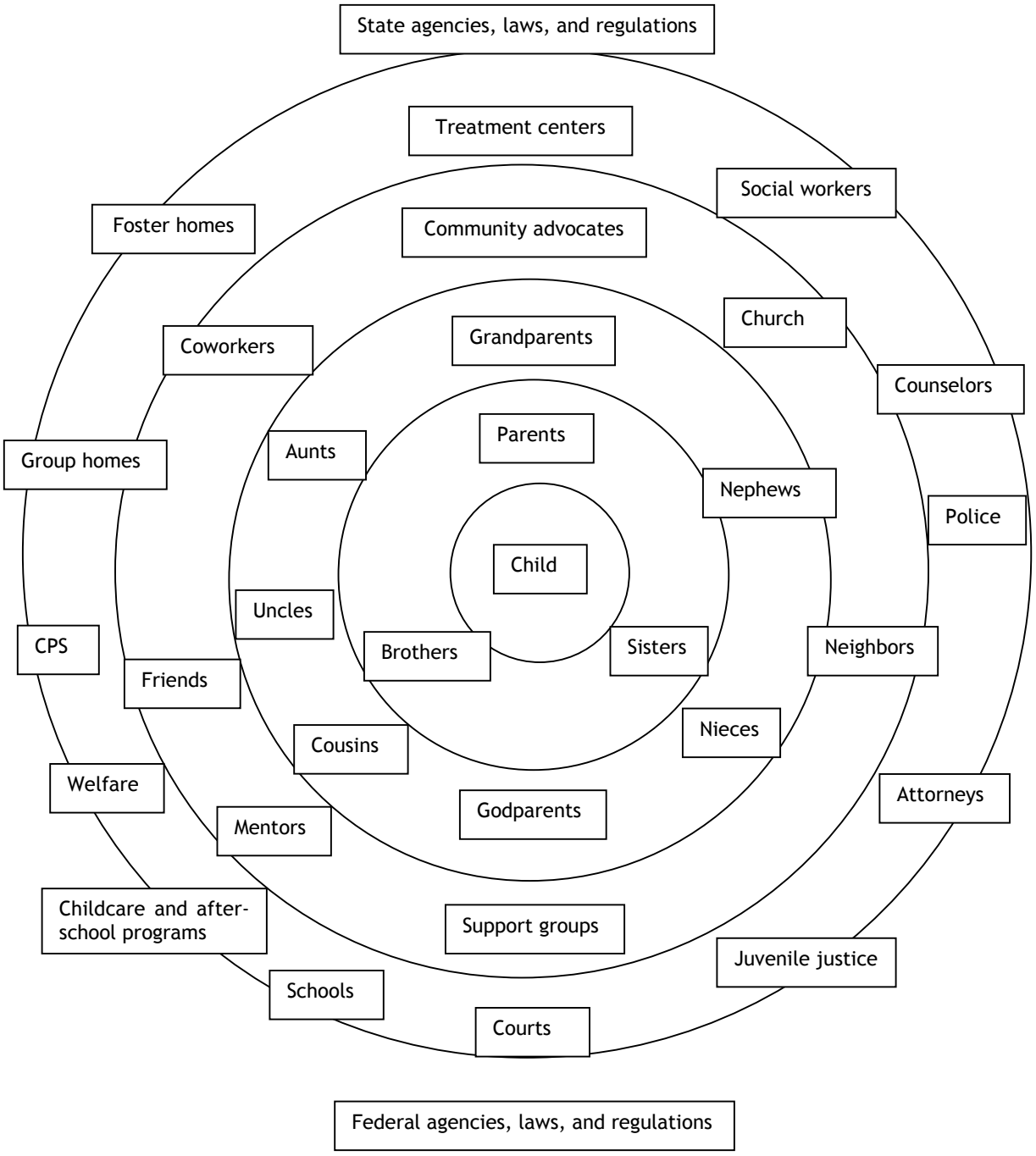

Figure 1: Formal and Informal Partners in the System of Care

Following are ten essential elements of wraparound services:

1. Families have a high level of decision-making power at every level of the wraparound process.
2. Team members persevere in their commitment to the child and family.
3. Wraparound efforts are based in the community and encourage the family's use of their natural supports and resources.
4. The wraparound approach is a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
5. Services and supports are individualized, building on strengths and meeting the needs of children and families across the life domains to promote success, safety, and permanency in home, school, and the community.
6. The process is culturally competent, building on the unique values, preferences, and strengths of children, families, and their communities.
7. The plan is developed and implemented based on an interagency collaborative process with the community or neighborhood.
8. Wraparound plans include a balance of formal services and informal community and family resources, with eventually greater reliance on informal services.
9. Wraparound teams have adequate and flexible funding.
10. Outcomes are determined and measured for the system, for the program, and for the individual child and family (Burns & Goldman, 1998).

Balanced and Restorative Justice

Restorative justice is defined as a process whereby parties with a stake in a specific offense decide collectively how to deal with the aftermath of an offense and its implications for the future. Acknowledging that crime causes injury to people and communities, restorative justice aims to repair those injuries and enables the parties to participate in that process. Restorative justice programs, therefore, enable the victim, the offender, and affected members of the community to be directly involved in responding to the crime. They become central to the criminal justice process with state and legal professionals becoming facilitators of a system that promotes offender accountability; reparation to the victim; and full participation by the victim, offender, and community (Van Ness, 2000).

Restorative justice is different from contemporary criminal justice in several ways. First, it views criminal acts more comprehensively. Rather than defining crime as simply lawbreaking, it recognizes that offenders harm victims, communities, and themselves. Second, it involves more parties in responding to crime. Rather than giving key roles only to government and the offender, it includes victims and communities as well. Finally, it measures success differently. Rather than measuring how much punishment is inflicted, it measures how many harms are repaired or prevented (Van Ness & Brookes, 2000).

The National Center for State Courts reported that implementing a restorative justice approach is a major trend in the juvenile justice system, especially in Pennsylvania, Florida, and Minnesota (National Center for State Courts, 1998). Some counties in California, such as Shasta and Santa Cruz, are also implementing this approach to juvenile justice. A restorative justice approach provides a framework for systematic reform and offers hope for preserving and revitalizing the juvenile justice system. Implementing this new approach involves developing new missions and goals for juvenile justice; reallocating resources; redesigning job descriptions; developing new reporting measures and data collection systems to monitor effectiveness; giving priority to new programs and practices; and developing new roles for victims, citizens, and offenders in the justice process (Bazemore & Umbreit, 1997).

Challenge Grants

The Juvenile Crime Enforcement and Accountability Challenge Grant Program is administered by the Board of Corrections. The

purpose of this program is to reduce juvenile crime and delinquency. Counties were awarded grants based on developing and implementing a comprehensive, multi-agency action plan that provides for a continuum of responses to juvenile crime and delinquency. Counties also needed to demonstrate a collaborative and integrated approach for implementing a system of swift, certain, graduated responses and appropriate sanctions for at-risk youth and juvenile offenders.

To be eligible for a grant, a county must establish a multi-agency juvenile justice coordinating council that develops and implements a continuum of county-based responses to juvenile crime. The coordinating councils develop a comprehensive, multi-agency plan that identifies the resources and strategies for providing an effective continuum of responses for prevention, intervention, supervision, treatment, and incarceration of juvenile offenders, including strategies to develop and implement locally based or regionally based out-of-home placement options for youth.

Counties receiving grants are also required to identify outcome measures, including the rate of juvenile arrests, the rate of successful completion of probation, and the rate of successful completion of restitution and court-ordered community service responsibilities.

Healthy Families

The Healthy Families Program provides low-cost health insurance for uninsured children and youth up to their 19th birthday who are not eligible for no-cost, full-scope federal Medi-Cal and whose family incomes are below 250 percent of the federal poverty level. The Healthy Families Program provides health, dental, and vision coverage. For mental health services, the health plans are responsible for 20 outpatient visits per year for evaluation, crisis, and treatment for conditions that can benefit from relatively short-term intervention and 30 days of inpatient care. The health plan is also responsible for medication and laboratory services to treat those mental conditions.

Children with serious emotional disturbance enrolled in the program can receive additional mental health services. Upon determination by a county mental health program that an enrollee has a serious emotional disturbance, the full range of medically necessary services available through the Medi-Cal Rehabilitation Option and Targeted Case Management programs will be provided to the extent resources are available.

Healthy Start

The Healthy Start Support Services for Children Act, Chapter 759, Statutes of 1991 (SB 620, Presley) is California's first statewide effort to place comprehensive support services for children and families at school sites. Healthy Start brings together schools, school districts, county offices of education, health and human services agencies, county governments, nonprofit organizations, businesses, and others to focus their collective energy, expertise, and resources on responding to the needs presented by children, youth, and families in the school community. The intent of Healthy Start is to improve the lives of children and families by the following actions:

- Creating learning environments that are optimally responsive to the physical, emotional, and intellectual needs of each child
- Fostering local interagency collaboration and communication to deliver education and support services more effectively to children and their families
- Encouraging the full use of existing agencies, professional personnel, and public and private funds to ensure that children are ready and able to learn, and to prevent duplication of services and unnecessary expenditures
- Building on the strengths of children and families and providing and enhancing opportunities for parents and children to be participants, leaders, and decision-makers in their communities

Healthy Start does not necessarily pay for services. Rather, it provides coordinated service delivery that links children and families to needed supports and services. These school-linked supports and services that are being offered to meet the needs of Healthy Start children, youth, and families include:

- Child protection, parenting education, and child care

- Food, clothing, shelter, and transportation
- Vision care, hearing, dental care, acute care, and preventive health care
- Therapy, support groups, and substance abuse services
- Tutoring and dropout prevention
- Career counseling, job placement, and job training
- Recreation and youth development
- Income maintenance through Medi-Cal, Temporary Assistance for Needy Families, and food stamps

The first statewide evaluation revealed that from January 1993 through March 1995 schools experienced statistically significant school-wide improvements in standardized test scores for grades one through three, increased parent participation, and reductions in student mobility. Children and families intensively served through Healthy Start showed improved results in every area examined.

WHAT POPULATIONS NEED SPECIAL ATTENTION?

Although the California public mental health system has made great strides in the last 15 years developing a Children's System of Care, specific issues and groups of children should be examined to ensure that children, youth, and families benefit from the system of care outcomes. This section emphasizes some important issues and identifies certain categories of children, youth, and families with continuing or emergent needs for mental health services.

Conditions of Poverty for Children and Youth from Diverse Racial, Ethnic, and Cultural Populations

Conditions of poverty are a serious at-risk issue for families. The National Institute for Mental Health (NIMH) indicates that low-income individuals are two to five times more likely to suffer from a diagnosable mental disorder than individuals in the highest socioeconomic status (Bourdon, Rae, Narrow, Manderscheid, & Regier, 1994). Poverty also poses significant obstacles to getting help for these mental health problems.

In 1998, child poverty was at 18.9 percent in the United States, representing 13.5 million children. Although whites represented the largest single number of persons in poverty in 1998, ethnic groups were overrepresented with 26.1 percent of African Americans, 25.6 percent of Latinos, 12.5 percent of Asian American and Pacific Islanders, and 31 percent of American Indians on reservations who were living in poverty, compared with 8.2 percent of whites who were poor. The majority of poor families had a female as head of household.

The American Psychological Association's Public Interest Directorate, "Resolution on Poverty and Socioeconomic Status" listed the following findings about conditions of poverty:

- The effects of poverty on young children are significant and long-lasting resulting from substandard housing, homelessness, inadequate child care, unsafe neighborhoods, and lack of resources in schools
- Poor children are at greater risk than higher income children for a range of problems, including poor academic achievement, poor socioeconomic functioning, developmental delays, behavioral problems, poor nutrition, low birth weight, and medical illnesses
- Poor environmental factors have detrimental effects on mental and physical development
- Migrant families are by nature of their work and conditions, poorly served by health and mental health professionals
- Undocumented immigrants are vulnerable to legal actions that inhibit their access to health and mental health professionals

Refugee Children and Their Families

Between 1997 and 2001, according to the California Department of Social Services Refugee Programs Branch, 50,544 refugees arrived in California, including 12,157 children. These children are vulnerable physically and emotionally since they are exposed to multiple traumas, including torture and possibly death of parents, grandparents, and siblings; witnessing war firsthand; loss of their home, friends, and community; hunger and violence; and a sense of powerlessness to hold onto those

things that would normally give them comfort, security, and sustenance. Many of these children have physical problems caused by inadequate nutrition, inattention to chronic medical conditions, and injuries suffered before or during flight. Many children have emotional problems caused by loss or separation from parents and other family members, feelings of alienation from their country and community of origin, anxiety resulting from perceptions of parental powerlessness to protect them from the negative consequences of the refugee experience, and a sense of disorientation and loss of identity (CASSP Technical Assistance Center, 1989). After arriving in the United States, they must contend with the following issues:

- Reconfiguration of families with changes in the family unit due to death, divorce, or having a family member remain in the county of origin. One Los Angeles study noted that of 136 refugee families, 97 did not include both biological parents.
- Change in traditional gender roles where in countries of origin women generally care for the children and home while the males are the breadwinners of the family. In the United States, such roles are threatened. Refugee women often find work more easily than men causing considerable divisiveness between husband and wife with resultant stress on the children.
- Parent-child role reversal with children becoming cultural brokers, interpreters, and making or greatly influencing major social and economic decisions for their family.
- Intergenerational conflict with children adopting different behaviors, values, and expectations from those of their parents.
- Parental acculturation failure leading to parents having difficulty preparing children for adult life and difficulty retaining their children's attention and respect.
- Increased possibility of child neglect and abuse resulting from parental depression and sense of powerlessness.
- Difficulty mastering the English language leading to frustration, especially for teens, with resulting acting out behavior.
- Residence in low-income, high-crime areas with accompanying poverty, drugs, and violence resulting in corruption, exploitation, and mistrust of both community members and society at large. This setting and these attitudes become major barriers for families to overcome.

Given these issues, it is not surprising that many refugee children and adolescents exhibit, at least for a time during periods of stress, problems including anger, relationship difficulties, distorted value systems, and acting out behaviors. Prolonged stress during migration and acculturation result in high incidence of mental health problems, including post traumatic stress disorder; major depression; paranoid symptoms; mania; and "refugee neurosis," characterized by insomnia, nightmares, somatic complaints, problems with personal relationships, mistrust, and social isolation (CASSP Technical Assistance Center, 1989).

Although refugee families and their children have substantial need for mental health services, many barriers exist to the use of mental health services by refugee families, including:

- Non-existent or inadequate outreach efforts
- Lack of bilingual and bicultural staff who can overcome the fear of not being able to communicate physical or emotional problems due to lack of English skills
- Unwillingness to trust Western medicine or service providers
- Lack of money to pay for treatment
- Fear that seeking services might reveal illegal immigration status
- Differing cultural norms on expressing suffering and sensitive emotional concerns

To overcome some of these barriers, mental health service delivery systems for refugee children and families are best linked to health clinics that are the first providers of care for refugees. These health clinics provide baseline medical examination and screening for diseases common to the county of origin. Co-locating mental health facilities with health clinics allows families to become aware of other available services and encourages them to use the services as needed.

Children Age 0-5

The National Institute of Mental Health estimates that at least 7.5 million children have diagnosable psychological disorders that significantly affect the quality of their lives. Research has demonstrated the powerful role that early identification, intervention, and meaningful support and assistance can have for these children and their families. This knowledge has led to increasing awareness of the factors that contribute to adaptive and maladaptive patterns of development in infants (California Infant Mental Health Work Group, 1996).

The brain research literature provides striking evidence that an early focus on children can pay big dividends later in life. These findings support the idea that, although the shaping of the brain continues long after birth, the first years are critical for the full development of a child's cognitive abilities. Research on brain development provides important support to the research examining the relationship between family risk factors during childhood and poor life outcomes for children in such environments. These bodies of research point to ways in which families and society can ameliorate the effects of environmental stress on children (Illig, 1998).

Infant mental health refers to a comprehensive perspective on social and emotional well-being in infants and toddlers and the processes that support it. Infant mental health depends upon a number of factors, including the interactions between parents and a child and the child's relationships with other caregivers and siblings (California Infant Mental Health Work Group, 1996). Through positive interactions, the infant acquires pleasurable feelings about self and others, the capacity to relate to others, feelings of value and self-worth, a sense of having an impact on one's world, and a sense of belonging to family and community. The basic foundations of infant mental health include:

- Parent-infant-family attachments and positive interactions
- Caregiver capacity to read and respond to infant cues
- Infant capacity to initiate and respond to caregiver interactions
- Availability of social supports
- Parental capacity to use social supports (California Infant Mental Health Work Group, 1996)

The infant and family well-being can be affected by vulnerabilities within the family environment, such as poverty, biological and health factors, substance abuse, domestic discord, community violence, and other stress factors (California Infant Mental Health Work Group, 1996). Infants are born to parents with a range of capacities to initiate and respond to all aspects of their environment. Thus, a continuum of interventions must be available ranging from promotion of best parenting practices, anticipatory guidance, and development of parenting skills to critical interventions with severely dysfunctional infants and their families (California Infant Mental Health Work Group, 1996).

Delivery of effective, family-centered infant/toddler mental health services is dependent on well-trained health, mental health, education, developmental services, and social services professionals. Staff should be experienced in the care of children from birth to three years of age, able to facilitate child/caregiver relationships, assist in positive behavioral development, and provide grief and crisis counseling.

To expand the capacity of the public mental health system to serve this population, the Department of Mental Health (DMH) funded four counties as a pilot project. This initial effort is now being expanded due to an award of $3.6 million from Proposition 10's California Children and Families Commission. The framework and funding for the Infant Family Mental Health Initiative is based on existing efforts in training, model development, capacity building, and evaluation of the Infant Mental Health Development Project funded by

the Department of Developmental Services and coordinated by West Ed/CEITAN.

The goals of the Infant Family Mental Health Initiative are to:

- Identify the early childhood/infant and family mental health needs, resources, and services within pilot counties
- Increase the capacity of county mental health departments to identify and serve very young children and their families
- Facilitate interdisciplinary and interagency collaboration for services and staff training
- Provide models, resources, funding options, and replicable approaches for the delivery of effective mental health services for infants and their families

Evaluation is a significant part of this initiative and will involve developing procedures for both ongoing and overall evaluation of project outcomes, including:

- The results of a feasibility study based on screening and treating 10 infants and families in each county
- Changes in service delivery
- Personnel development
- County capacity to provide infant-family mental health services
- Staff training and supervision

Child Care and After-school Care

Children with serious mental health needs generally exhibit behaviors related to their condition at childcare and after-school care. In fact, such conditions may first be manifested in these settings. The children's symptoms and behaviors often result in frustration for the care provider who usually has had no training in identifying serious emotional disturbances or the skills for responding constructively to the child's needs. If the symptoms include aggressive, acting out behavior, the child is typically expelled by the care provider. This expulsion adds pressure to a family system that is likely struggling with the same behaviors. Such expulsions and loss of continuity result in increased stress to the child and further exacerbate the child and family's difficulties.

Childcare and after-school care are ideal places for early identification of serious emotional disturbances and intervention. Ideally, through training in mental health identification and referral and ongoing support, care providers will be able to maintain more children with serious emotional disturbances in their current care situations. At the same time the care provider will learn techniques and gain understanding that will benefit all children in the provider's care.

Risk Issues in Education

The 2000 US Census is a resource for studies that underscore risk issues for specific ethnic youth. School dropout rates reflect a particular problem. For example, a study conducted by the American Association of University Women revealed that Latina females drop out of school at a far greater rate than any other group of females in the United States. According to an analysis of the census data, 26 percent of Latina females leave school without a diploma compared to 13 percent of African American and 6.9 percent of white females. Latino males have an even higher dropout rate at 31 percent. Among other males, the dropout rate is 12.1 percent for African Americans and 7.7 percent for whites. Language barriers and poverty, especially for children of migrant workers, have been noted as sources of increased dropout rates (Canedy, 2001).

Children and Youth in Foster Care

The number of children entering the child welfare system and the percentage of those with significant mental health problems has increased significantly. In the last two decades, the number of children in the nation entering the foster care system has increased 60 percent. Studies suggest that the increase is due to rising rates of neglect related to parental drug and alcohol abuse, poverty, homelessness, AIDS, and domestic violence in at-risk families (Barbell, 1997). California has the largest child welfare system in the nation. Twenty percent of the nation's one-half million children in out-of-home care are dependents of the California child welfare system. The number of children in out-of-home placement in California increased 30 percent from 56,957 in 1994 to 87,387 in 1998 (Marsenich, 2002).

The age and ethnicity for children in foster care has also changed. Increase in parental

drug and alcohol involvement accounts for the growing number of children aged 0 to 5 entering foster care (Needell, Webster, Barth, Armijo, & Fox, 1998). In 1983, the average age for children in foster care was 10 years, 2 months. By 1990, the average decreased to 8 years, 3 months. By 1997, 33 percent of the children in out-of-home care in California were under 5 years of age. The representation of ethnic children in foster care has changed from 54 percent of the caseload in 1983 to 70 percent in 2001. African American children represent 36 percent, and Latino children represent 31 percent of children in out-of-home care.

The estimate for the proportion of children entering the foster care system with significant mental health problems ranges from 35 to 85 percent, depending on the study. Incidence of emotional, behavioral, and developmental problems among children in foster care is three to six times greater than that for other children (Brestan & Eyberg, 1998). The mental health service utilization rate for children in foster care generally is high relative to other children. One California study concludes that foster children represent only four percent of children on Medi-Cal but represent 41 percent of service users (Halfon, Berkowitz, & Klee, 1992).

Significant disparities in access to mental health services exist along ethnic and gender lines. Boys in foster care with severe psychiatric disorders are more likely to receive medication than girls. When problem severity is high, whites and African Americans of either gender have a higher service utilization rate than Latinos, Asians, and other ethnic groups. Whites have the highest rate of service utilization when the problem severity rate is low. Latinos have a low mental health service rate for all problem severity categories (Garland et al., 2000).

Youth in the Juvenile Justice System

Studies have shown that children in the juvenile justice system have high rates of mental illness (Evens, 1997). The prevalence of mental disorders among youth in juvenile justice facilities ranges from 50 to 75 percent in multiple, well-designed studies that used structured diagnostic interviewing techniques to determine children's diagnoses (National Mental Health Association, 1999). However, youth in the juvenile justice system, especially those incarcerated in juvenile justice facilities, face substantial barriers to receiving mental health services. Medi-Cal reimbursement is only available for youth in juvenile justice facilities that have been adjudicated and are awaiting placement. Other youth in juvenile justice facilities are not eligible for Medi-Cal; consequently, many counties are not able to fund the needed mental health services for these youth. Moreover, juvenile justice facilities and the California Youth Authority are experiencing widespread over-crowding. Caseloads for juvenile probation officers are often high, precluding the ability to provide individualized services involving the family. An overriding concern is that youth suffering from mental illness who have been incarcerated do not have access to adequate mental health services.

In addition to these problems facing all children in the juvenile justice system, racially and ethnically diverse youth are over represented in the juvenile justice system (Macallaire & Males, 1999) (Poe-Yamagata & Jones, 2000). Based on arrest data from Los Angeles County, "The Color of Justice" (1999) concludes the following:

- Racially and ethnically diverse youth are 2.7 times more likely than white youth to be arrested for a violent felony
- Once in the system, racially and ethnically diverse youth are 3.1 times more likely than white juvenile crime arrestees to be transferred to adult court
- Racially and ethnically diverse youth are 8.3 times more likely than white youth to be sentenced by an adult court to a California Youth Authority (CYA) facility. In 1980, white youth comprised 30 percent of the CYA population. By 1998, white youth comprised only 14 percent of the CYA population.
- CYA projects that Latino youth will represent 65 percent of the CYA population in the next several years

"And Justice for Some: Differential Treatment of Minority Youth in the Justice System" (2000) concludes that the juvenile justice system is

"separate but unequal," especially for African American and Latino youth. Major findings include the following:

- African Americans and Latinos are over represented in both prisons and secure juvenile facilities
- In 1998, African American youth were overrepresented in number of arrests in 26 of 29 offense categories documented by the FBI
- Although racially and ethnically diverse youth comprise one-third of the adolescent population in the United States, they comprise two-thirds of over 100,000 youth confined in local detention and state correctional systems
- When white youth and racially and ethnically diverse youth with no prior admissions were charged with the same offenses, African Americans were six times more likely and Latino youth three times more likely than white youth to be incarcerated in public facilities

The Children's System of Care should develop and support program strategies that will increase access to mental health services and divert racially and ethnically diverse children and youth from the juvenile justice system. Recent studies suggest causes for the under-utilization of the mental health system by ethnically and racially diverse families. Ethnic minority parents are less likely than white parents to choose formal mental health providers when deciding where their children should get help (Cauce et al., 2002). In one study of families who eventually came into contact with a mental health agency related to their children's emotional problems, white parents were more likely to have contacted mental health professionals themselves than African American or Latino parents (McMiller & Weisz, 1996). Research indicates that African American families may be less likely to seek mental health services voluntarily compared with other ethnic groups due to a perception that services may be ineffective or that barriers to services may exist (Neighbors, 1985).

Outreach efforts and establishing culturally responsive services in ethnic-specific service centers may be necessary to encourage voluntary service utilization among African Americans and Latinos. Evidence from a recent study of referral patterns in San Diego, California lends credence to the effectiveness of ethnic-specific services for increasing voluntary access to mental health services by ethnic families. Latino youth in San Diego were more likely to have been referred to mental health services by family and were less likely to have entered services through a mental health agency than were non-Hispanic whites (Yeh et al., 2002). The researchers speculate that this referral pattern may result from the availability of ethnic-specific outpatient clinics in the San Diego area.

The Report of the Surgeon General's Conference on Children's Mental Health recommends other actions that will help resolve these disparities:

- Develop strategies to serve uninsured children and youth across diverse populations and geographic areas
- Monitor access to mental health services through a continuing quality improvement process, which includes analyzing ethnic-specific data. The goal of this process is to equalize access to mental health services and to produce comparable outcomes of care across ethnic groups
- Identify and eliminate barriers to access based on ethnicity, culture, socioeconomic classes, gender, and sexual orientation to newly initiated or mandated programs
- Increase access to culturally competent services that are sensitive to youth and family strengths and needs
- Increase efforts to recruit and train providers who represent the racial, ethnic, and cultural diversity of the State (U.S. Public Health Service, 2000)
- Co-locate mental health services with other key service systems, such as education, welfare, and primary care, to improve access, especially in remote or rural communities
- Encourage and develop strategies to include and engage racially and ethnically diverse families in family

partnership, prevention, and intervention strategies

- Increase research on diagnosis, prevention, treatment, and service delivery to address disparities, especially among different racial, ethnic, gender, sexual orientation, and socioeconomic groups

Youth with Dual Diagnoses

All children and youth should be screened for potential alcohol and other drug use. If such use is identified, a substance use assessment should be completed, and a substance abuse treatment plan should be coordinated with the mental health plan, integrating mental health and drug and alcohol treatment. This combined treatment approach may require cross-training in screening, assessment, and treatment for mental health and alcohol and other drug staff as well as for education, probation, and other child serving agencies.

Results from the DMH's performance outcome system show that clinicians are reporting that approximately 15 percent of the youth they assess have moderate to severe impairment regarding substance use. However, estimates from national studies of co-occurring mental disorder and substance abuse among adolescents range from 22 to 82 percent (Substance Abuse and Mental Health Administration, 1999). The prevalence of co-occurring emotional and behavioral problems and addictive disorders varies across studies because of methodological complexities of studying this issue. However, this study by the Substance Abuse and Mental Health Administration (SAMHSA) also cites evidence that over 30 percent of 16- to 17-year-olds report using alcohol in the past month with past-month alcohol use being nearly twice as likely for adolescents with serious emotional disturbances. Dependence on substances, such as cocaine, crack, inhalants, hallucinogens, heroin, or abused prescription drugs was nearly 9 times as likely among adolescents with serious behavioral problems. Comparing national estimates of co-occurring emotional and behavioral problems and addictive disorders with results from California's performance outcome data on children and youth suggest that mental health clinicians may not be identifying all youth with substance abuse problems.

The need to diagnose substance use disorders among youth with serious emotional disturbances is underscored by the increased incidence of suicide among adolescents and young adults. In 1997, suicide was the third leading cause of death for persons age 10 to 24. Annual surveys indicate that up to 7 percent of high school youth have attempted suicide. Co-occurring mental and substance use disorders have been identified as precursors and risk factors for youth suicidal behavior. For adolescent males who complete suicide, comorbid conduct disorder, mood disorder, and substance use disorder are the most common diagnoses. For adolescent females, mood disorders predominate with lower rates of comorbid substance use disorders and conduct disorders compared to adolescent males. (National Institute of Mental Health & National Institute of Drug Abuse, 2000)

Transition-age Youth

The upper age limit for youth eligible for services in the Children's System of Care varies based on the funding source for the individual child. Children generally move to the adult system at age 18. Medi-Cal eligibility for some youth continues past age 18 because they are eligible for Supplemental Security Income or Temporary Assistance to Needy Families or because of their status as a child formerly in foster care. These youth are eligible for Medi-Cal funded mental health services up to age 21. Those with Healthy Families insurance can receive services through that source until age 22. Finally, students eligible for services through Chapter 26.5 are generally eligible for those services until they graduate from high school, get a General Education Diploma, or reach age 22, whichever comes first.

When youth with mental health needs become too old for services from the Children's System of Care, they often face overwhelming obstacles making a successful transition to adulthood. In disproportionate numbers, they become pregnant or develop substance abuse problems. Homelessness is also a significant risk for many youth with mental health conditions. They often try unsuccessfully to live with their families, then turn to living with friends in unstable arrangements, and too often end up in jail, the hospital, or homeless.

Like all young people, youth with mental health problems need assistance with income, safe and affordable housing, independent living skills, and educational and vocational planning. They also need assistance learning and integrating social skills and finding appropriate social activities and relationships. As they develop their identities, they need to experiment with different lifestyles and choices, sometimes making mistakes that teach life lessons. Unlike other youth, they need mental health services and must manage their symptoms while moving to independence. Some have little or no support from parents. Research has shown that mentoring is a powerful force in the lives of young people, especially those who have a disrupted relationship with parents.

Education for these youth is often interrupted and disjointed. Many do not reach their educational potential due to multiple changes in schools, including enrollment in special education and non-public school classes. They need support in the most normative educational settings possible. Innovative programs with community colleges can provide a welcome second chance in an environment more accepting of diversity than the public school systems.

Employment for young people can be a stabilizing and normalizing activity, providing the opportunity to learn work skills and identify interests and to see themselves as successful members of mainstream adult society. Youth need vocational counseling, job placement, and job coaching to choose, get, and keep desirable employment.

Peer relationships are important for adolescents and young adults as they separate from adult caretakers and develop their identity. Youth this age often need and welcome assistance with learning how to make and keep friends, how to form successful intimate relationships, how to develop a satisfying social life, and how to manage their emotions.

Transition-age youth are sensitive to the stigma attached to having a psychiatric disability. They generally prefer to have opportunities to participate in the normal activities of this age: attending school, dating, driving, working, and living in a place of their own. These wishes should be respected.

When providing services to youth in transition, the following guiding principles should be followed:

1. A single service coordinator should follow transition-age youth who are at risk of homelessness until age 25.
2. Clients should not be rejected or ejected from services for exhibiting the symptoms of their illness or for the experimentation that is a hallmark of this developmental stage.
3. Services should be provided in the community or at clients' homes, according to the preference and convenience of the client.
4. Peer support, self-help groups, and mentoring are essential to successful transition-age services.
5. All staff that work with transition-age youth should be trained in the developmental needs of this population, in community resources, and in operationalizing a recovery philosophy.

To meet the needs of these youth, mental health programs must work in partnership with the following child-serving agencies and adult agencies:

- Employment and training agencies
- Independent living programs
- The systems of care for children and adults
- Court advocates
- Probation
- Housing and redevelopment departments
- Homeless programs
- County Offices of Education and school districts
- Community college districts

Gender Issues

In 1999, the California Institute for Mental Health issued a report on issues related to mental health services and treatment for women. This report highlighted the needs of young girls, which are not addressed by the

Children's System of Care. The report states, "Current practice frequently discounts the significance of gender-linked issues such as abuse and trauma, and allocates insufficient attention and resources to mental health problems most prevalent among women, such as eating disorders, depression, and post-traumatic stress disorder" (California Institute for Mental Health, 1999, p. 7). To redress this imbalance in the system of care, county mental health departments should develop early identification and intervention strategies designed to reduce development of more serious mental health problems.

Another problem that the report identifies is that, in counties funded by Children's System of Care grants, more boys than girls are receiving services. The report speculates that this imbalance may result from a need to prioritize mental health services due to inadequate funding. Boys tend to exhibit problems related to externalizing behaviors, such as aggression; girls tend to have internalizing problems, such as depression. When determining who has the greatest need for services, clinicians would most likely identify externalizing problems as having higher priority. Now that the Children's System of Care has access to additional funding through EPSDT, clinicians need to assure that the mental health needs of young girls are addressed.

WHAT ARE THE BARRIERS TO EFFECTIVE OPERATION OF THE SYSTEM OF CARE?

Lack of State Level Coordination

Structures for interagency collaboration have been created at the county level; however, interagency coordination at the state level has never been addressed effectively. Over the past few years, interest in providing services to children and their families has increased dramatically. These initiatives have been developed by diverse state departments and agencies. For example, the Department of Social Services within the Health and Human Services Agency has responsibility for innovative wraparound programs for children at risk of out-of-home placement. The DMH administers many children's programs, including the system of care allocations. The Board of Prison Terms in the Youth and Adult Corrections Agency administers the probation challenge grants. The Department of Education has responsibility for the Healthy Start program administered through the school districts.

Although all these programs are very beneficial to children and their families, they also create challenges to local agencies due to incompatible administrative requirements that occur because the various state agencies do not work together to develop compatible programs. Moreover, these programs can also be burdensome to family members, who may be put in the position of having to provide duplicative information on the functioning of their children for assessment, treatment planning, and program evaluation purposes.

To address these concerns, the State should establish a Children's Council that would have the following goals:

- Establish a common vision for services to children and their families
- Ensure collaboration among state agencies and departments
- Establish a common data set and local accountability for child and family services

Membership should include:

- Secretary, Health and Human Services
- Chair, Board of Corrections
- State Superintendent of Public Instruction
- Governor's Education Advisor
- County Supervisors Association of California
- Judicial Council
- Secretary, Youth, Adult, and Correctional Agency
- Chief Probation Officer representative
- Attorney General
- Juvenile Justice Commissioners
- Parent and youth representatives that reflect the racial, cultural, and ethnic diversity of the population to be served

Many state policies and programs are actually implemented on the local level by county agencies. To assure that coordinated state initiatives are implemented with maximum

collaboration at the local level, the Children's Council of Statewide Associations should also be established. The purpose of the association would be to develop a shared vision and operationalize it through the following methods:

- Education and technical assistance
- Cross-training among local agencies
- Convening joint conferences and scheduling joint committee meetings
- Blending outcomes, funding, and the populations to be served

Membership should include:

- Chief Probation Officers of California
- California Conference of Local Health Officers
- County Health Executives Association of California
- County Alcohol and Drug Program Administrators Association of California
- County Mental Health Directors Association
- Child Welfare Directors Association
- Special Education Local Plan Area Directors Association
- Families and Youth that reflect the racial, cultural, and ethnic diversity of the population to be served

Flexible Use of Funds for Improved Child Outcomes

Improving access to necessary resources will help to ensure the success of children and families. One of the unintended outcomes of years of specifically focused funding streams has been the "barriers" created by the inability to develop "blended funding streams" that complement the service system integration efforts. Examples of this complex funding for children's mental health services include these sources:

- Medi-Cal, including EPSDT and managed care consolidation
- Chapter 26.5 (AB 3632)
- Allocations from the SAMHSA Block Grant
- Healthy Families
- DMH's Children's System of Care allocations
- Realignment
- Other federal grants

Additional fiscal resources for children include federal, state, and local public and private funds in various forms, such as the Supportive and Therapeutic Options Program (STOP) funds, Temporary Assistance for Needy Families, CalWORKS, Probation Challenge Grants, special education, Healthy Start, SB 163 Foster Care Waiver funds, grants, pilot projects, and other targeted funds that must be woven into the system of care.

Public funding for services for children tends to be categorical; that is, it is available through mandates or programs for the exclusive use of a relatively narrowly defined population. These funds are available for only a specific set of services rather than for any services appropriate to the needs of a child and family. Examples of categorical funding are Chapter 26.5 funds, which are entitlements for students who have been found to require mental health services in order to benefit from their educational program. Another example is Medi-Cal funds, an entitlement for children under the age of 21 who are Medi-Cal eligible and who have a mental health diagnosis. Healthy Families is for children who do not qualify for Medi-Cal but who live in families whose income is below 250 percent of the poverty rate.

Categorical funding is like a puzzle with some pieces missing: if a child or group of children does not fit into any of these categories, the only option is to fund services through county realignment funds. To protect these scarce non-categorical resources, a county may be forced to have a different, narrower set of criteria for services and a more limited range of service options for these children than for children eligible for services through Medi-Cal or Chapter 26.5.

Problems resulting from categorical funding are also evident when children are in need of out-of-home placement. Placement in a group home will be paid for by public funds if a child has been made a dependent of the court because of abuse or neglect by a parent or

caretaker, has been made a ward of the court because the child has broken the law and is under the supervision of the Probation Department, or is eligible for services under Chapter 26.5. To be eligible for services under Chapter 26.5, a child must need a mental health service in order to benefit from their education.

If a child does not meet any of these conditions and the parents cannot afford the high cost of group home care, which can cost $8,000 per month or more (including board and care, mental health services, and education), the child may fall through the cracks and not be able to access group home services. At this point, families may start to disintegrate as they attempt to find resources for a child squeezed out by federal and state policies that provide access to services only through categorical funding streams. Parents sometimes abandon their child in order to gain access to care. Systems sometimes look for any technicality they can find to make a child a ward or dependent. The most logical solution to this problem would be to increase non-categorical funding for services to children and families and to loosen the categorical restrictions on the various funding streams.

WHAT ARE THE GOALS AND OBJECTIVES FOR THE SYSTEM OF CARE FOR CHILDREN AND YOUTH?

GOAL 1: Redefine the Children's System of Care.

OBJECTIVE 1: Expand the definition of the population to be served by the Children's System of Care to include all children and youth who receive services from the primary child-serving agencies, including children who are potentially eligible for those services.

OBJECTIVE 2: Ensure that a cultural, ethnic, linguistic, and age-appropriate screening tool for assessing the needs of children and their families is developed and adopted by all child-serving agencies in the system of care.

GOAL 2: Advocate for more flexible, less categorical funding for the Children's System of Care.

OBJECTIVE 1: The State Legislature should appropriate a pool of non-categorical funds for each county system of care to be used flexibly by the child-serving agencies to meet the needs of children and their families.

OBJECTIVE 2: State agencies that oversee child-serving agencies in the counties should apply for waivers to federal agencies so that federal funds can be used to maximum benefit for children and their families.

OBJECTIVE 3: County government should establish a savings pool for funds that are saved by not placing children in high-cost, restrictive settings so that those funds can be redirected to meet the needs of children and their families.

GOAL 3: Ensure that Interagency Policy Councils and Interagency Case Management Councils function effectively.

OBJECTIVE 1: The membership of the Interagency Policy Council should be expanded to include parents of a minor child and youth representatives that reflect the racial, cultural, and ethnic diversity of the population to be served.

OBJECTIVE 2: The CMHPC should conduct a study of the existence and functioning of these councils. This study should include:

- Whether membership matches statutory mandate
- Whether parents and youth are represented
- Whether the councils function as described in statute

GOAL 4: Ensure that children, youth, and families that reflect the racial, cultural, and ethnic diversity of the populations to be served are involved in all aspects of planning, delivering, and evaluating services.

OBJECTIVE 1: Involve children, youth, and families in service delivery.

A. Children, youth, and their families should be fully involved in all stages of service delivery: assessment, establishing goals, treatment planning, referrals for ancillary services, evaluation of progress, and transition planning for service termination.

B. Supervision of provider staff should emphasize child and family involvement at all stages of treatment.

C. Quality improvement reviews should emphasize child and parent involvement.

OBJECTIVE 2: Involve children, youth, and families in county system of care policy, planning, and evaluation.

A. Mental health boards and commissions should include parents of children who have been served by the public mental health system.

B. Mental health boards and commissions should include youth up to age 25 who have been in the public mental health system.

C. Parents and youth should be included in all county mental health policy, planning, and advisory groups for mental health, including management teams.

D. Parents and youth should be included on the boards of directors or advisory boards of all agencies that have contracts to provide county mental health services to children and youth.

OBJECTIVE 3: Hire parent partners and youth advocates to provide peer support and advocacy to parents and youth receiving services.

A. Youth who have received mental health services should be hired as youth advocates/peer counselors by both county-operated programs and community agencies.

B. Parents of children who are now or have received mental health services should be hired as family advocates by both county-operated programs and community agencies.

OBJECTIVE 4: Ensure that youth and families are involved in all aspects of state mental health policy, planning, and evaluating services.

A. Youth up to the age of 25 who have been in the children's mental health system should be represented on all state committees and advisory groups, including the CMHPC.

OBJECTIVE 5: Ensure involvement of ethnically diverse children, youth, and families in the Children's System of Care.

A. When overseeing the process of facilitating involvement of children, youth, and families in service delivery, supervisors should be proficient in understanding the multicultural and multilingual needs of these clients.

B. The orientation and training components for children, youth, and families should address the multilingual and multicultural needs of clients.

C. All levels of management and supervision, including quality improvement programs, are responsible for ensuring the involvement of ethnically diverse children, youth, and families in the Children's System of Care.

D. County mental health programs must conduct outreach to ethnic communities for participation on community boards and commissions.

GOAL 5: Expand the Children's System of Care to meet the needs of refugee and immigrant children, youth, and their families.

OBJECTIVE 1: Outstation mental health services in non-traditional locations, such as public health clinics serving refugees.

OBJECTIVE 2: Develop ways to serve immigrant children who do not have access to Medi-Cal and to mental health services.

OBJECTIVE 3: Train clinicians, supervisors, and management in treatment modalities most appropriate to addressing the needs of immigrants and refugees.

OBJECTIVE 4: Recruit members of immigrant and refugee communities as volunteers and outreach workers to reach these children and youth in need.

OBJECTIVE 5: Perform ongoing research for evidence-based practices to address the needs of immigrant and refugee children, youth, and their families.

GOAL 6: Advocate for expansion of infant mental health pilot programs.

OBJECTIVE 1: The CMHPC shall assist the DMH in disseminating information about the need for culturally and linguistically appropriate infant mental health programs and strategies.

OBJECTIVE 2: If the infant mental health pilot program currently implemented by the DMH produces positive outcomes for young children and their families, the CMHPC will urge the Legislature to appropriate funds for all counties to provide infant mental health programs.

OBJECTIVE 3: If the infant mental health pilot program is expanded, efforts should be increased to identify those ethnically diverse children who are at the highest risk for mental health problems.

GOAL 7: Expand mental health services for children with serious emotional disturbances in childcare and after-school care by ensuring early identification, referral for assessment, and early intervention through training and consultation for care providers.

OBJECTIVE 1: Develop collaboration among the Departments of Education, Mental Health, Social Services, and Developmental Disabilities to address the behavioral and mental health needs of young children in child and after-school care and to provide training and resources for child care providers.

OBJECTIVE 2: Identify legislative and regulatory methods for developing and maintaining services within the county mental health service delivery system for young children, families, and child and after-school care providers.

OBJECTIVE 3: Develop sustainable, local infrastructures to facilitate training and provide supervision of county child care mental health consultants.

A. Establish a team of trained child and after-school care mental health consultants in each county with the capacity to provide support and direct services to the child care community

B. In collaboration with education and training institutions, develop a training-of-trainers model and curriculum for mental health professionals who wish to work as consultants to child and after-school care providers. This curriculum shall include the following topics:

   - Child development
   - Early childhood mental health issues
   - How to provide consultation services within the context of child and after-school care

C. Include the following topics in training for child and after-school care providers:

   - When to seek mental health consultation
   - How to identify children who may need mental health services
   - How to identify specific problematic behaviors
   - How to communicate effectively with mental health professionals and parents
   - How to access mental health services for children and their families

OBJECTIVE 4: Develop evaluation protocols for child and after-school care mental health and behavioral health consultation services in order to stimulate policy formation and program development.

OBJECTIVE 5: Develop procedures for billing child and after-school care mental health consultation services through Medi-Cal; Early Periodic Screening, Diagnosis and Treatment; and other funding streams, such as private insurance.

GOAL 8: Develop strategies for early identification and early intervention to prevent children and youth from entering the foster care system.

OBJECTIVE 1: Conduct studies of all components of the Children's System of Care to identify biases that lead to differential service referral patterns among ethnic groups and lack of sufficient availability of culturally and ethnically responsive services.

OBJECTIVE 2: At the local, state, and federal levels, systems must acknowledge the implications of the incompatible goals of the mental health and child welfare systems and work toward agreement on compatible, complementary alternatives to foster care.

GOAL 9: Expand the availability of mental health services for youth in juvenile justice facilities.

OBJECTIVE 1: The State should ensure greater coordination between the Board of Corrections, the California Youth Authority, and the DMH regarding oversight of juvenile justice facilities and the provision of mental health services to youth in juvenile justice facilities.

OBJECTIVE 2: The Legislature should increase appropriations for all funds that can be used for mental health services for youth in juvenile justice facilities.

OBJECTIVE 3: The DMH should participate in monitoring the provision of mental health services to youth in juvenile justice facilities to determine whether access to services is increasing.

GOAL 10: Reduce the overrepresentation of multicultural children in juvenile justice settings.

OBJECTIVE 1: The State should require each county to track the rate by race and ethnicity of their county's children in the juvenile justice system as a part of the county's quality improvement activities.

OBJECTIVE 2: If large overrepresentation exists in the number of racial and ethnic children involved in the juvenile justice system, counties should develop strategies in collaboration with other child serving agencies for early identification and early intervention to prevent children and youth from entering the juvenile justice system.

A. Conduct studies in all service settings to identify racial profiling, biases within systems, and lack of sufficient availability of culturally and ethnically responsive services.

B. Develope alternative strategies along with effective partnerships to break an otherwise increasingly punitive and more restrictive cycle of intervention.

C. Target mental health resources to meet the needs of these children.

GOAL 11: Increase the identification of substance abuse problems in children and youth.

OBJECTIVE 1: The State should adopt a screening tool to identify children and youth with substance abuse problems.

OBJECTIVE 2: The State should implement an extensive training program of staff in all child-serving agencies to enhance their ability to identify children and youth with substance abuse problems.

OBJECTIVE 3: The State must eliminate disincentives for children and youth to disclose their substance use problems. Child-serving agencies must be able to assure children and youth that their self-disclosure of substance use will remain confidential and will not result in negative consequences, such as arrest, incarceration, or revocation of probation.

GOAL 12: Develop a service system for transition-age youth in every county. The service system should have the following components:

OBJECTIVE 1: Every mental health provider, including the Adult and Child Access Teams, that serves youth age 14 to 25 should identify a minimum of one transition-age specialist who can be a resource on issues such as housing, income, vocational services, education, mentoring, and peer self-help.

OBJECTIVE 2: A transition-age coordinator should be hired to provide monitoring of mental health programs serving transition-age youth, oversight, coordination, and linkage between the child and adult systems, other partners, and the child and adult programs.

OBJECTIVE 3: When a youth receiving mental health services reaches age 14, a transition plan should be developed and implemented to assist in the transition to the adult system.

OBJECTIVE 4: Children's service coordinators should review all open mental health cases as their clients turn 17. Any necessary linkage and referrals to the Adult System of Care, housing, vocational services, and other services should be identified and carried out in a timely manner.

OBJECTIVE 5: Interagency case conferencing should be held on a regular basis to coordinate services for youth who are experiencing especially difficult challenges. Relevant partners should attend and coordinate necessary services to stabilize the youth.

OBJECTIVE 6: A specialized transition program should be developed to provide services, including rehabilitation services and service coordination, for youth ages 18 to 25 who have significant mental health needs and are at risk

of homelessness. The transition program should perform the following functions:

- Refer youth to specialists in housing, vocational services, education, income maintenance, socialization skills, alcohol and other drug services, and coordinate these services as needed.
- Provide system level coordination through case conferences.
- Support the development of self-help groups.
- Teach living skills, social skills, dating, and how to make and keep friends outside of institutional living by using directed experience in the community rather than a didactic approach and by discussing new experiences with the youth.

OBJECTIVE 7: Provide housing services with the following components:

- A revolving fund for lending money for deposits and first and last months' rent
- Support to assist youth to maintain subsidized housing
- Crisis respite housing
- Short-term shelter beds
- Apartment clusters

OBJECTIVE 8: Develop Youth Centers for all youth in the community to provide opportunities for socializing and recreation with a specific component of peer support for youth with mental health conditions.

OBJECTIVE 9: Assist clients to obtain their high school diploma or GED and to go as far as possible in higher education. Provide educational support in the form of tutoring, mentoring, and coordination with the education system.

OBJECTIVE 10: Develop partnerships with employment training agencies to provide job referrals, assistance with applications, and job coaching.

OBJECTIVE 11: Recruit, train, and coordinate volunteer mentors who represent the racial, ethnic, and cultural diversity of the population served.

OBJECTIVE 12: Establish a coalition of advocates and other stakeholders to monitor the adequacy of services for youth in transition to make recommendations to improve services.

GOAL 13: Advocate for creation of a state-level Children's Council and Children's Council of Statewide Associations

OBJECTIVE 1: The CMHPC should work with the California Institute for Mental Health (CIMH) and the California Mental Health Directors Association (CMHDA) to determine what steps have already been taken to implement this goal.

A. In collaboration with CIMH and CMHDA, the CMHPC should initiate contact with the Administration to urge the creation of a state-level Children's Council.

B. In collaboration with CIMH and CMHDA, the CMHPC should convene a meeting of statewide children's associations to plan for the creation of a Children's Council of Statewide Associations.

OBJECTIVE 2: These state-level groups should work to ensure that state regulations, required local advisory groups, outcome measures, and paperwork requirements are consistent and not duplicative for the child-serving agencies in a county implementing state-mandated programs.

OBJECTIVE 3: The state-level groups should work with local agencies to eliminate duplicative data gathering for families being served by more than one local agency.

GOAL 14: The state-level Children's Council should develop a statewide outreach campaign to eliminate disparities in mental health programs for children and youth and a parent education program about how to access services for children and their families.

OBJECTIVE 1: The state-level Children's Council should study the causes of disparities in access to services for ethnic children and youth and use the results of this study in developing their statewide campaign.

OBJECTIVE 2: At the local level, the Interagency Policy Councils should implement the campaign developed by the Children's Council to eliminate disparities in mental health programs and to educate parents about how to access mental health services.

GOAL 15: Eliminate racial, ethnic, and socioeconomic disparities in access to mental health care for children and youth with serious emotional disturbances.

OBJECTIVE 1: Require county mental health programs to use their quality improvement process to study access to mental health services among racial and ethnic groups to determine if disparities in access to services exist for multicultural children and their families.

A. County mental health programs should use performance indicators, such as penetration rates, expenditures per client for outpatient services, and units of service per client for outpatient services, to study access to mental health services.

B. The State should require that a quality improvement plan be implemented to correct the disparities in access to mental health services for multicultural children and their families.

- ♦ Identify barriers to access based on ethnicity, culture, or socioeconomic class to children's mental health programs, including any newly initiated or mandated programs.
- ♦ Develop strategies in program planning and service delivery that eliminate the historical barriers that racial and ethnic families face, including alienation, racism, and powerlessness, to access to mental health services for children and their families.

C. The State should require a plan of correction in counties with large disparities in access to services for multicultural children.

OBJECTIVE 2: Increase research on diagnosis, prevention, treatment, and service delivery to address disparities in access to mental health services for children and their families, especially among different racial, ethnic, immigrant, refugee, and socioeconomic groups.

OBJECTIVE 3: The State, in consultation with the CMHDA and the CIMH, should identify evidence-based practices to reduce disparities and to increase service access for multicultural children and youth.

OBJECTIVE 4: Increase efforts to recruit and train providers specializing in children's mental health services who represent the racial, ethnic, and cultural diversity of the State.

APPENDIX

SERVICES AND PROGRAMS PROVIDED BY COUNTY MENTAL HEALTH DEPARTMENTS

The mental health dimension of a system of care must have all the basic components available to meet the needs of children and their families. These components include screening, assessment, developing a client plan, service coordination, a full array of service options, flexible support services for the family, staffing, and advocacy. It must reflect the cultural and linguistic characteristics of the community. The planned system of care for children and youth should have components that integrate and infuse a cultural competency plan throughout. Cultural competency should be reflected in all of the areas that follow.

Screening

The mental health system of care must have a screening procedure to identify those children and youth that may need services. A Mental Health Screening Tool for use with children aged 5-18 provides professionals a simple way to identify children who should be referred for a full mental health assessment.

For those children and youth that do not meet the criteria, the system should make appropriate referrals so the child or youth accesses support elsewhere in the community. Thus, the system should perform the following functions for all children and families seeking services:

- Triage and crisis evaluation
- Consultation
- Information and referral
- Assistance in identifying appropriate services
- Outreach to identify children and youth through connections with other service systems and the community

Assessment

All services should be based upon a dynamic, comprehensive biopsychosocial client assessment, which results in a coordinated client service plan. A medical examination should be part of the assessment. The assessment must document that the client has a mental health diagnosis, has a functional impairment, and requires services.

The assessment shall ascertain psychiatric condition, living arrangements, individual and family strengths and needs, functioning in school and in the community, social relationships, and physical condition. The needs and wishes of the child and family must also be considered. All previously gathered relevant and available information on a child or youth should be reviewed to minimize unnecessary or duplicative testing.

The assessment shall be completed within 30 days unless the child or youth is in an emergency situation, i.e., the child or youth is dangerous to self or others or is unable because of a mental disturbance to take advantage of food, clothing, and shelter. In these instances, services may be provided without a full-scale assessment or plan.

Client Plan

Service planning will be done with age-appropriate participation of the child or youth, the family, representatives of other agencies with which the child and family are involved, and individuals who the child or family invite, such as a youth or family advocate, friend, or support person.

Services are planned across three dimensions: setting, intensity, and variety. Service settings could include any appropriate place for delivering care, such as home, school, a foster home, shelter care, juvenile justice facility, or other community location. Service intensity relates to the frequency with which the service is provided and to its duration. Service variety refers to the treatment and

supportive services available. In developing an individual treatment plan, all three dimensions must be addressed so that the plan meets the unique characteristics of the child and family.

Every child or youth in the system of care shall have a client assessment plan. It shall:

- Be developed within 60 days of the assessment
- Partner with the client, family members, legal guardian, significant others, and representatives of other agencies providing services
- Contain the client's long-term goals
- Contain specific objectives linked to the client's strengths and functional impairment
- Identify specific services the client will receive and who will provide them
- Utilize the least restrictive, most appropriate mental health setting for the child or youth at every stage of service delivery
- Be reviewed and updated at least every six months based on the child or youth's changing needs and conditions
- Provide for evaluating the child or youth's progress toward achieving the plan's goals
- Specify discharge readiness criteria, i.e., when services will no longer be necessary

Service Coordination

A system of care needs a comprehensive system for service coordination to provide services in accordance with the changing needs of a child and family. Each local mental health program shall develop a comprehensive system to accomplish the following goals:

- Always be the fixed point of responsibility for the child and family and be the interface with all service providers and agencies
- Partner with children and their families in planning for and deciding upon treatment options
- Assist families in obtaining necessary services for their children and themselves
- Assist the child and family to develop internal and external supports and to connect the child and family to natural resources in the community
- If indicated, assist families in applying for public entitlements, such as food stamps, scholarships, rent subsidies, and Supplemental Security Income, and in learning to use them
- Provide support to the client during transitions between programs utilizing interagency agreements and flexible funding as required by the individualized service plan
- Keep the family and client fully informed
- Advocate for the client's needs by identifying gaps in the system and bringing them to the attention of both management and the Interagency Children's Policy Council
- Protect and advocate for the rights of children and youth

Service Options

Service options are an array from which needed services may be selected. Services not already available in the community should be created. Services can be provided alone or in combination with each other. Combining various modes of treatment with services of other agencies can often generate creative uses of traditional treatment approaches. Coordinated treatment plans developed in concert with other agencies serving the child and family can enlist the aid of non-mental health professionals, such as special education teachers, probation officers, foster parents, or social service workers. Such concerted efforts by all the providers in a child's life increase the probability of positive treatment outcomes.

The array of services includes the following:

- Individual and group therapy
- Family therapy
- Medication and medication monitoring
- Day treatment
- Crisis intervention available 24 hours per day, seven days per week
- Secure community treatment facilities
- Acute hospital care
- Intensive in-home services
- Rehabilitative services
- Respite services for families
- Other services as identified by the child, family, and treatment team that will meet the individual and unique needs of the child and family

Staffing

Staffing standards should be based on the number of children and youth served and the children and youth's acuity levels. Each local program should develop such standards, and treatment providers should adhere to them. All treatment programs must provide and document a specific plan of supervision for children and youth being treated covering all hours that children and youth are present. Staffing patterns at all levels should reflect, to the maximum extent feasible, the cultural, linguistic, ethnic, and other social characteristics of the community. In addition to mental health professionals, staffing should also include peer providers, such as family advocates and youth advocates. Paraprofessionals should be enlisted to provide additional resources to assist in attaining goals.

Advocacy

Each local program must have a patients' rights office to ensure that the rights of children and youth and their families are protected, to bring deficiencies to the attention of the local mental health director, and to take remedial action. The patients' rights office shall have 1) access to children and youth and their records; 2) access to mental health providers; 3) authorization to invoke penalties for noncompliance with rights; and 4) an established grievance procedure for children and youth and their families.

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